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ABSTRACT

This manual, geared for mental health professionals, demonstrates that social network intervention provides an excellent framework and set of tools for working with the multiple problems of older adults. Social networks are "family" groupings of client, family members, friends and other community supports. The intervention focusses on bonding and strengthening such "family" systems into a network that helps improve the overall quality of life for the elderly. Topics and exercises include: (1) mental health service delivery problems; (2) assessment and intervention stages of the social network approach; (3) special intervention techniques helpful in working with the elderly; and (4) issues on the quality of life for the elderly. (Author/BMW)

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A SOCIAL NETWORK APPROACH TO WORKING WITH ELDERLY CLIENTS

Training Manual for Mental Health Professionals

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Editors

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DEDICATED TO THE PROVISION OF QUALITY HUMAN SERVICES

TO THE RESPECTED ELDERLY

ACKNOWLEDGEMENTS

Many persons contributed to the evolution of this manual. The chapters contain the material presented in lectures to participants in several training projects. The editors have rewritten and condensed this material and take full responsibility for the final product and for the exercises. We hope we have conveyed the essence, if not the complete substance, of the consultants' ideas.

Most of our consultants have been students or faculty at the School of Professional Psychology. However, one consultant, Ellen Mack Bates, is Geriatrics Coordinator for the Denver Health and Hospitals Mental Health Programs and we give her special thanks for her help.

Special appreciation is also extended to David Becker for his work on the pilot project and for his initial planning for social network training for mental health center personnel. Mitchell Berdie has contributed direction and counsel throughout as has Martin Dubin.

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Finally, we are most appreciative of the participation of the administration and staff of the mental health centers (Southwest, Arapahoe, Bethesda, Denver Health and Hospitals, Adams County and Park East), the nursing home personnel in each catchment area and the residents and their social networks. Without their sharing in this experience, this project might never have come to be!

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August 15, 1979

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CHAPTER 1. INTRODUCTION

Mental health professionals who work with the elderly may often feel overwhelmed by the many physical and psychosocial problems of late adulthood.

> "Old age is the period of life with the greatest number of profound crises, often occurring in multiples and with high frequency. The critical psychological events in this age group are the familiar human emotional reactions to death and grief, diseases and disabilities. Depression and anxiety escalate, defensive behavior is seen, earlier personality components may reappear in exaggerated forms, and newly formed functional states are frequently noted. These conditions require psychotherapeutic efforts, in depth as well as supportive." (Butler and Lewis, 1977, p. 1)

We have been able to demonstrate that social network intervention provides an excellent framework and set of tools for working with the multiple problems of late adulthood. Social networks are "family" groupings of client, family members, friends and other community supports. The focus of the intervention is on bonding and strengthening such "family" systems into a self-perpetuating network which helps improve the overall quality of life for the elderly.

Background: A direct-service pilot study undertaken by faculty and students of the University of Denver School of Professional Psychology in the spring of 1977 demonstrated the value of social network intervention with elderly nursing home residents. Therefore, we planned and implemented a program to train mental health center staff and nursing home personnel within selected catchment areas in understanding elderly clients and their psychosocial needs.

During three phases of ten weeks each in 1978-79 personnel from six Denver metropolitan area mental health centers and nursing homes within each catchment area attended training sessions and worked directly with nursing home residents to apply lecture and reading materials. On-site consultations were held during each phase. Positive participant evaluations attested to the utility of the training.

This training manual presents in concise form the material that the project participants indicated was most useful in their understanding of and work with elderly clients. Although this material was developed in projects focusing on nursing home residents, information included should also be helpful to mental health professionals dealing with the elderly living alone or with families. Within the general focus on social network formation, other intervention techniques are presented and special issues discussed. We have obviously not attempted to provide comprehensive coverage of all possible intervention techniques or issues of aging.

It is our hope that the manual will be useful to geriatrics coordinators in training staff to work with older clients and as an adjunct to inservice presentations. It may also serve as a guide for other professionals in their assessment and intervention efforts with this special population.

Manual Guide: We encourage the reader to explore the entire manual. However, individual chapters may be selected according to interest. Since max-

imum learning occurs with combined reading and practice, exercises are included in each chapter. The timing and structure of these exercises are flexible to meet training needs.

- Chapter 2 describes mental health service delivery problems as related to the elderly. Exercises are designed to increase awareness of needs of and services to the elderly and to identify informational and attitudinal views of the elderly.

- Chapter 3 covers the assessment and intervention stages of the social network approach while Chapter 4 focuses on the family system. Exercises in these chapters involve practical applications of the systems approach described.

- Chapter 5 discusses special intervention techniques helpful in working with the elderly. The first exercise promotes understanding of resident council formation while the others offer practice opportunities for the other techniques.

- Chapter 6 alerts the professional to two issues important to the quality of life of the elderly person. The exercises are designed to raise consciousness.

The editors will appreciate hearing from those who use the manual as to its utility, results of applications of techniques described and suggestions for future improvements.

REFERENCE

Butler, R. and Lewis, M. Aging and Mental Health. St. Louis: C.V. Mosby, 1977.

CHAPTER 2. FACTORS AFFECTING MENTAL HEALTH SERVICES TO THE ELDERLY

A. COMMUNITY MENTAL HEALTH SERVICES AND THE ELDERLY

Mitchell Berdie

Late adulthood does not bring immunity from mental health problems. The elderly are susceptible to the same range of difficulties as are younger adults. In addition, there are characteristics of aging and the life styles of the elderly which place them at greater risk for certain problems. One such characteristic is the fact that the lives of the elderly are filled with losses of spouse, loved ones, friends, social contacts, work, status, valued roles, physical health and freedom of choice.

> "Losses in every aspect of late life compel the elderly to expend enormous amounts of physical and emotional energy in grieving and resolving grief, adapting to the changes that result from loss, and recovering from the stresses inherent in these processes." (Butler and Lewis, 1973, p. 29)

Also, the elderly often find themselves in poverty. In 1975 it was reported that 50 percent of elderly couples had an income of less than $5000 per year, while more than 70 percent of the single elderly had incomes of less than $3000 per year (Moss and Moss, 1975). Exacerbated by inflation, financial concerns often lead to increased anxiety and depression.

To meet the needs of the elderly, mental health services must have certain characteristics: 1) services must be accessible to a population with limited mobility and finances, 2) services must not take the view that mental health problems are primarily intrapsychic and 3) agencies must be able to conduct programs which counteract or avoid the stereotype many elderly have about mental health services.

In theory comprehensive community mental health centers (CMHC) are well suited to provide services to the elderly. The system is designed so that it is accessible, with centers located within relatively small catchment areas and fees charged on a sliding scale.

A basic tenet of the community mental health movement is the concept of human behavior as the result of the interaction of intrapsychic and environmental variables. Using this approach, assessment of the elderly would carefully examine the effects of such factors as physical disorder, social interactions and poverty with intervention entailing comprehensive programs to address both intrapsychic and "real world" needs of the elderly.

Community mental health centers are also mandated by law to provide consultation and education services, giving CMHCs the capacity to consult with other institutions serving the elderly, such as nursing homes, senior centers and public housing. In turn, this allows mental health input into program design, staff education and case management. Furthermore, services may also include the kind of outreach efforts necessary to encourage the elderly to utilize mental health services.

If the promise of community mental health centers has been a bright beacon, the reality of CMHCs and the elderly has been more like a dim flashlight.

An examination of one state's experience serves to illustrate the limits of actual service delivery to the elderly. In Colorado the elderly constitute approximately 9 percent of the population. While CMHCs in Colorado serve a mean of 1.8 percent of the persons in their catchment area, they serve a mean of only 0.46 percent of the elderly in their catchment area. Elderly clients served range from .08 percent of the total served in a core city center to 1.56 percent of the total served in a rural center with a high ethnic density (Berdie, 1978). Clearly, elderly persons are underserved compared to other age groups.

The reasons for this scarcity of services are varied. The current generation of elderly represent a population which may be reluctant to utilize available services. Also, mental health center staff may have little training and/or experience in working with the elderly. They may also have detrimental ageist attitudes.

A major barrier to services for the elderly results from legislation. The total amount of money appropriated for CMHCs by federal and state sources has not increased substantially, even though the federal legislature has recently mandated that they expand services to the elderly. Reimbursement structures also discriminate against the kinds of services which best meet the needs of the elderly. Home visits do not generate the equivalent revenue of office time because the cost of travel must be absorbed. In addition, the contract for service rates of reimbursement for consultation and education services are lower than for provision of direct service. Thus, even if CMHCs wish to mount a program to address the needs of the elderly, they are impeded by financial realities.

The social network approach to working with the elderly in or out of nursing homes offers a time- and cost-effective means of increasing services to the elderly, since the goal is a self-perpetuating social network. The mental health professional is involved only at inception. The network approach offers an exciting challenge for mental health professionals as conductors and catalysts for action using a systems approach.

EXERCISE

Purpose: To increase staff awareness of demography, needs and services for use by center administration, teams or individuals.

Exercise: Group discussion of the following questions:

1) How many elderly persons reside in your catchment area?
2) How many elderly clients are served by your center?
3) What percentage of your clients are elderly?
4) How many nursing homes, senior apartment buildings, recreation centers and nutrition sites are there?
5) How many staff members are involved in work with the elderly? Is there a geriatrics coordinator, specialized team, etc.?

REFERENCES

Berdie, M. Promises, Promises: Community Mental Health Centers and the Elderly. Presented at Colorado Mental Health Conference, Keystone, CO September, 1978.

Butler, R. and Lewis, M. Aging and Mental Health: Positive Psychological Approaches. St. Louis: C.V. Mosby, 1973.

Group for the Advancement of Psychiatry. The Aged and Community Mental Health. New York: G.A.P., 1971.
Moss, G. and Moss, W. Growing Old. New York: Pocket Book, 1975.

B. MENTAL HEALTH PROFESSIONALS AND THE ELDERLY

Martin Dubin

When examining the problems of mental health service delivery to the elderly, some attention must be given to the mental health professional. What prevents those in mental health from delivering services to the aged? The problem will be approached from three perspectives:

1) Anxieties and apprehensions about the aged may hinder appropriate service.
2) Myths, stereotypes and misinformation may result in therapists' avoidance of the aged.
3) Societal negation and devaluation of the elderly may influence the therapist's basic assumptions, often without his/her awareness.

Therapist Anxiety: Mental health professionals are taught that their effectiveness can be severely limited if they are unaware of feelings towards their client. The therapist's idiosyncratic problems, fears and anxieties can impede the therapeutic process. The elderly provide unique issues that the therapist must recognize.

The Group for the Advancement of Psychiatry (1971) has cited several fears which may affect the professional:

1) The aged stimulate the therapist's fears about his/her own old age. By avoiding contact with the aged the therapist can attempt to forestall or deny this fear. Old age and many of the issues associated with it, such as chronic illness, loss of family and friends, decreased physical capacity and attractiveness, retirement, dependency upon one's children, death, etc., may preclude therapeutic involvement.

2) The aged can arouse the therapist's conflicts about relationships with parental figures. Unresolved conflicts from childhood can make it difficult for the therapist to deal effectively with an aged client who reminds the therapist of his/her parent(s). Similarly, current conflicts with one's parents and fear of their old age, dependency and death can impel the therapist to avoid contact with aged clients.

3) The aged client may die while in treatment, thus challenging the therapist's sense of importance. Avoiding the elderly can protect the therapist from such a narcissistic blow.

4) The therapist may fear colleagues' reactions to involvement with the aged. Geriatric work is certainly not prestigious in our society, and pathological motivations may be attributed to those who work in this field.

In addition, the therapist may fear being overwhelmed by the diversity of the problem. At no other point in the life cycle are physiological, psychological and social factors so intertwined. Many therapists are uncomfortable with physical disease and its manifestations. Except for those with medical

or nursing training, most therapists have an inadequate knowledge of physical disorders and are uncomfortable with including the physical sphere in a treatment plan.

Therapists may also be anxious about the increased dependency of the aged. The therapist may not know whether to foster or discourage this dependency in the therapeutic relationships.

Finally, courses and practical experience in working with the aged, clinical case studies and research in the area are scant. Therefore, the therapist may be anxious over the lack of theoretical and clinical framework.

Myths, Stereotypes and Misinformation: Myths and misinformation concerning the aged and their life styles abound in our society. The mental health professional with a minimal background in gerontology is liable to misunderstand aged clients. Therapists may believe that they have nothing to offer elderly clients and may avoid them, believing that with increasing age comes an inflexible character resistant to change ("You can't teach an old dog new tricks"). Further, the erroneous assumption that intellectual abilities decline with age (Botwinick, 1967) may influence the therapist to believe that insight therapy with the aged is impossible.

A widely held assumption, even among mental health professionals, is that psychopathology in old age is due to irreversible brain dysfunction. This simply is not true in the majority of cases. Recent studies put the incidence of irreversible brain pathology at less than 10 percent in those over 65 (Palmore, 1977). Furthermore, much brain disease is acute and amenable to treatment and many functional disorders, especially depression, mimic some of the signs of brain disease.

Many problems of the elderly are dismissed as inevitable with age rather than as functional or organic disease entities. For example, sleep disturbances, often symptomatic of depression, are commonly missed due to erroneous beliefs about the amount of sleep an aged client requires.

Societal Negation and Devaluation of the Elderly: There are a multitude of ways in which the aged are discounted by our society and many of these cultural attitudes are shared by mental health workers. The mass media present a stereotype of the older person as ugly, lonely, isolated, lacking in energy and vigor, forgetful, rigid and requiring a multitude of remedies for failing physical and social capacities.

Another prevalent cultural conception of the elderly which has far-reaching effects upon mental health care is the perception of older people as highly dependent. Much of the dependency of old age is culturally determined, rather than the result of personality dynamics. Through various cultural and legal restrictions the aged are denied access to direct sources of wealth and power. This forced socio-economic dependency is due to our own idiosyncratic cultural definitions.

There is also a common cultural conception that the aged have little to offer other members of our society, that they have no reciprocal role to fulfill in social interactions, that they are functionless, useless and therefore dependent because they request but do not provide. In contrast, in some societies

and subcultures the aged have economic resources and also retain moral and judicial functions (Spencer, 1965, Simmons, 1945).

Finally, our society has a future and present time orientation in terms of social exchange value. Past deeds are not held to be as worthwhile as present or future potential (Clark, 1969). This cultural convention devalues the elderly and may encourage therapists to think that their skills are being wasted.

In view of all the above, programs may have to be available within mental health centers to help mental health professionals working with the elderly with their anxieties, stereotypes and cultural attitudes.

EXERCISE

Purpose: To identify individual information and attitudes on aging and to discuss these in small groups.

Exercise: Discuss the myths and stereotypes held by society and how these affect your view of late adulthood. Comment on how these myths are perpetuated by the mass media. Discuss what anxieties you have about working with the elderly.

REFERENCES

Botwinick, J. Cognitive Processes in Maturity and Old Age. New York: Springer, 1967.

Butler, R.N. and Lewis, M.L. Aging and Mental Health (Second Edition). St. Louis: C.V. Mosby Co., 1977.

Clark, M. Cultural Values and Dependency in Later Life. In R.A. Kalish (Ed.), The Dependencies of Older People. Ann Arbor: Institute of Gerontology, University of Michigan-Wayne State University, 1969.

Palmore, E. Facts on Aging. The Gerontologist, 1977, 17, 4, 315-320.

Simmons, L.W. The Role of the Aged in Primitive Society. New Haven: Yale Universities Press, 1945.

Spencer, P. The Sambru: A Study of Gerontocracy in a Nomadic Tribe. Los Angeles: University of California Press, 1965.

CHAPTER 3. THE SOCIAL NETWORK: ASSESSMENT AND INTERVENTION

Evelyn Paley, Timothy Dea and Mitchell Berdie

The task of social network intervention is to organize and/or strengthen a maximally effective and reliable social system in support of an older person. In harmony, the network can articulate the individual's needs and supply the necessary resources for actively coping with a range of problems. Although most older persons can be helped by social network intervention, problems of social isolation, loneliness and depression are particularly relevant.

Psychosocial (affective) needs may be met and nurtured by involving family, friends, clergy, volunteers and others. These individuals can supply the emotional and social supports which are so often absent or diminished due to progressive losses. The physical (instrumental) needs (i.e., housing, medical care, finances) can be fostered not only by the family, but also by social services such as community agencies, visiting nurses and senior groups. The elderly may need these resources, but may not be aware of or able to contact them.

Assessment: The assessment of affective and instrumental needs is at the heart of quality intervention. Symptoms such as anxiety, withdrawal, agitation and belligerence are frequently attributed to intrapsychic causes or to organic deterioration. However, such behavior is often evidence of a dysfunctional social system. The professional who is familiar with a social systems framework has an added tool in identifying and alleviating such problems. This framework serves as a guide to the kind of information to be gathered and provides a way of interpreting data to plan an effective treatment strategy.

It is important to make certain assessments before intervening in a social system. Garrison and Howe (1976) suggest four factors:

> "1) are there resources in the client's social environment that could be beneficial?; 2) are any caregivers involved in the case open to a network approach?; 3) will the client consent to convening the important people in his/her life?; and 4) can the responsible clinician think of any reason not to use a network approach?" (p. 330)

In addition, one must assess the reasons that the system is prevented from operating to support the older person and the changes necessary to mobilize the network. A clear behavioral definition of the problem and the solutions which have been tried is essential. This information is gathered during the initial exploration and continues as new data become available.

Sources of information can include the client, family members and friends. In the case of a nursing home resident, valuable information can be gained by speaking to the staff. They may have observed: Who visits and how often? What is the comfort level and content of the visits? Do members confront each other directly, or do they use staff as a buffer or as the target of complaints? Information about the complainer and the nature of the complaints is useful. For instance, a daughter may complain for the entire family but do so only after her brother has visited the parent.

Assessment is an ongoing part of the therapeutic process and allows the intervener to modify strategy where necessary to insure lasting change and continued network support.

Intervention: Assuming that assessment indicates the need for strengthening or establishing a social network, a meeting of potential participants should be planned. The network meetings are not therapy in the usual sense and because the word "therapy" may arouse anxiety, it should be specifically avoided. Meetings conducted in a social gathering atmosphere will facilitate positive group interaction. Ideally, they should be conducted in the client's current residence in order to create familiarity and control and to minimize stress for the elderly client. Meetings can be arranged by either the mental health professional, the client, a relative or a significant person in the system. Evening times are often the most convenient for meetings due to the work schedules of the network members. The explanation for convening can revolve around the rationale of gathering for a "problem-solving session where we will put our heads together (with the client) to help find a solution." (Garrison and Howe, 1976, p. 331)

The focus of the initial meetings and the cornerstones for effective intervention are:

1) Joining with the structure and helping to create an atmosphere of trust and acceptance. Without a solid relationship base, any intervention will be most difficult.
2) Defining and describing the problems as precisely as possible from each member's perspective.
3) Listing alternative solutions to the problems.
4) Inventorying the strengths and weaknesses of each alternative, including each member's opinions in order to insure a togetherness in problem-solving.
5) Choosing one solution and setting standards of performance for this solution. The more specific and measurable the criteria for success, the better.
6) If the solution involves a number of steps to completion, clarifying each step, setting standards and setting up network recognition for success at each step.
7) Having individuals and sub-groups accept tasks (such as visits, transportation).
8) Carrying out the plan.
9) Evaluating the results of the intervention, refining or starting over with a new goal if necessary. If there is progress, encouraging the entire network to recognize and reward the positive movement.
10) Planning for continuation of the network with progressively less professional involvement. This entails facilitating and supporting problem-solving strategies of the combined network from the very beginning of intervention.

CASE ILLUSTRATIONS

A 75 year old male nursing home resident diagnosed as chronic schizophrenic has been institutionalized for 37 years. After changing nursing homes he was quite isolated socially. He did not get along well with the sister who visited him. Otherwise, he shunned others because he considered himself their "intellectual superior." The staff person from our project worked with him and with the admini-

strator of the nursing home to develop a system of social contacts. Following this effort, the man sat and talked regularly with another resident who had been a teacher and who was his intellectual equal. The administrator took enough interest in him to become part of his network and future plans included the addition of an outside volunteer.

An 81 year old female demonstrated the effectiveness of a network in promoting successful aging. The volunteer working with this woman discovered an intact social network of two daughters, a close friend from work, a housekeeper, a nurse, a grandson who lived out of state but phoned once a week, two ladies in the dining room and an attorney. The volunteer's work consisted of meeting with the network participants to support them for the job they already were performing.

HYPOTHETICAL CASE ILLUSTRATION

An older woman is brought to the mental health center by her daughter who complains that: "Mother is paranoid." Following interviews with the family network, including the client, the professional notes that the family members have increasingly ignored her and consistently exclude her from mealtime conversations. The client feels that she is a burden and that the family wants to place her in an institution. Her only way of dealing with this threat is to berate family members for rejection and to be generally negative and often verbally abusive. It is further noted that the teen-aged children resent grandmother's presence and complain to their parents about the restrictions she places on their lives. The daughter and her husband are in a dilemma. On the one hand, they want grandmother to live with them; on the other hand, they would like a harmonious three-generation family.

Social network intervention might involve family meetings directed at improving communication channels, social skills training and possibly engaging the teenagers and grandmother in a life review (cf., Chapter 5). Intervention might also involve broadening the social network to include church, senior groups, etc. so that grandmother may become more independent of the family.

EXERCISE

Purpose: To practice assessment from a social network framework and to design an effective intervention based upon this assessment.

Exercise: Individuals present a past or current case to their group. Ongoing cases are preferable so that the professional can use immediate feedback to refine his/her assessment and intervention efforts. Group members:

1) Assess: a) who is in the network, b) the psychosocial needs which are being met and the instrumental needs which are being met, c) the needs which are not being met and d) the other resources which are indicated.

2) Develop a resource list for your catchment area including relevant city, county and state services to the elderly.
3) Plan the initial network meeting with the client. Who? Where? How?
4) Evolve a plan for ongoing system involvement using the problem-solving strategies discussed in this chapter.

REFERENCES

Caplan, G. Principles of Preventive Psychiatry. NY: Basic Books, 1964.

Garrison, T. Network Techniques: Case Studies in the Screening-Linking-Planning Conference Method. Family Process, 1974, 13, 337.

Garrison, T. and Howe, T. Community Intervention with the Elderly: A Social Network Approach. Journal of the American Geriatrics Society, 1976, 24, 7, 329-333.

Pattison, E.M. Social System Psychotherapy. American J. Psychotherapy, 1973, 17, 396.

Speck, R. and Attneave, C. Family Networks. NY: Pantheon, 1973.

CHAPTER 4. THE FAMILY SYSTEM

Jean Hoerl

The core of the social network for many, but certainly not all, older persons is the family. Therefore, an understanding of family structure, dynamics and intervention techniques is essential for mental health professionals.

The view of counseling with the elderly and their families to be presented here makes one major assumption: any problem presented by a client must be assessed in its social context, that is, the social network of the client, particularly his/her family. The presenting problem is frequently part and parcel of the behavior patterns of the total family. More specifically, the problem behavior typically has a place or function somewhere in a series of cyclical behaviors involving some other members of the family. To illustrate, if an elderly person living alone refuses to pay bills, does that reflect senility or does it reflect the need for the parent to attract the attention of a "child" who will otherwise be more likely to spend time accommodating a demanding spouse or children? Obviously the counselor must develop an ear for the social context of the presenting problem.

Within this framework the behavior of the older client is an integral part of the family patterns of behavior and calls for family counseling as the mode for problem resolution. The initial step is to bring the family together in order to further define the problem and to set goals. Anyone who has tried to accomplish this will know that it is not an easy task! Sometimes the elderly client will not want to meet with members of the family or members of the family will want nothing to do with the older person. Perhaps the older person, like a runaway child, does not want to meet with the family because of the discomfort caused by being trapped in the power struggle going on between two children or a child and a spouse. Perhaps children do not want to visit their mother because this sets up a power struggle among them. The possibilities are many and again the person trying to be useful in solving the problems of an older client should be aware of a myriad of possibilities.

What can be done to bring family members together? It is important to enter the system with a positive attitude about convening the family members. You can contact the members yourself, explaining how much help they can be in trying to understand the problem situation and the disadvantages of not having their participation. Occasionally you will have a client who is quite set on leading the process. This client may be encouraged to invite the relatives, thus utilizing and supporting a sense of effectiveness while fulfilling the goal of bringing the family together.

Many persons working with elderly clients are younger than the client. One useful way of overcoming this potential barrier to a helping relationship is to reverse the role and pose the problem as one in which the client can be helpful to you. Many people who do not want to be helped make very good helpers.

There will be times when few family members will agree to participate. More important than everyone's presence is your realization that, whether every-

one comes to a session or whether you end up meeting alone with one child of the client, you are still working on a family problem.

Assuming that you have obtained some agreement about holding a session, what are the important things to keep in mind? A key tenet of systems theory is that families operate in ways to preserve balance or regularity within the family and, like individuals, need a sense of predictability and control. The needs and desires of each member are balanced with the needs of the family as a whole, which then is in a state of homeostasis. This balance which has been achieved may not be optimal, but the regularity provides a level of comfort. For instance, in one family decisions may be regularly made only after consulting the dominant father. Therefore, other family members' ability to make decisions will be impaired since they have not practiced independent decision-making. The balance is upset if the father becomes seriously ill, incapacitated or has to leave the home and the family must then attempt to cope with unfamiliar decision-making. Signs of family confusion and disruption may result.

Each family has its own rules for maintaining homeostasis which change as the family passes through developmental stages. One set of family rules will characterize a family in which parents are in their fifties and children in their twenties with infant grandchildren. Quite another set will predominate in a family with eighty year old parents, fifty year old children, twenty year old grandchildren and infant great-grandchildren. These rules keep members functioning as a group.

An equally important characteristic is the extent to which family members exist as individuals within the unit. Each family member has unique boundaries within the family. These boundaries are norms and expectations about family interactions. For example, a family in which everyone is enmeshed in the total unit may be reluctant to place a relative in a nursing home despite the necessity for constant skilled nursing care. Conversely, a family in which there is little concern among individuals for the total family unit may prematurely decide to place a relative in a nursing home. The mental health professional must, therefore, assess boundary relationships among family members.

How the family interprets events is also important. One cannot assume that families will react to events in any one way or that any one reaction will characterize an entire family. For example, family members may react with varying levels of relief or grief to placement of an elderly relative in a nursing home; these reactions, in turn, may affect future involvement with the relative so placed.

The key to getting information about the family and gaining the leverage necessary for change is the skill with which one "joins" the family. Work with a family may be seen as alternating and intertwining phases of joining and challenging the family system. It seems obvious that you will not have the power to challenge the behavior or beliefs of the family unless you first have joined: established mutual trust, respect and understanding.

Minuchin (1974) refers to three major ways of joining a family: 1) tracking, 2) mimesis and 3) maintenance. Tracking behavior occurs on more than one level. On the one hand you are "tracking" the problem, getting a behavioral description from everyone present of what leads up to, encompasses and fol-

lows the problem and what has already been tried to alleviate the problem. Tracking also refers to the skills of a good communicator: 1) asking open-ended probing questions, 2) being direct and congruent in communications about yourself and 3) accurately reflecting back thought and feeling. There are two important goals to be attained by listening well. One is to gain understanding of your client's experience and the second is to literally "get into" his/her language. The capacity to understand and to actually begin to use the family's language is very important when it comes to posing the challenges required for change.

Mimesis, or the imitation of the family's nonverbal behavior, also helps in the mutual identification process between you and the family. Recognizing and joining on the levels of speed (slow or fast), feeling tone (humorous or serious) and body posture (rigid or relaxed) can be useful for becoming one with the family as well as for creating an opening for change by initiating contrasting behaviors.

Maintenance refers to the recognition and support of the family structure. An important task is to identify who is in conflict with whom, who mediates, foresees or instigates these conflicts, who holds power and who holds none, who communicates with whom, through whom, etc. One of the principles behind the idea of maintenance as a joining technique is that change is best fostered by starting at the point where the family is functioning and moving slowly, with small steps, until reaching the end goal. Part of what must be assessed is how problem resolution can be accomplished with the least amount of system interference. For example, in a family where the children are earnestly trying to prove how good they are to their elderly parent, must the intentions behind what they are doing be confronted or can a resolution to the problem be posed in such a way that their attempts to be good are reinforced and redirected at the same time?

As the above illustration implies, joining and challenging the system are not discrete or separate tactics. With an understanding of the problem, recognition of the family structure and facility with the family's language, one moves swiftly into the steps toward the necessary change. A good guideline to keep in mind is never to take away a behavior without replacing it with another. For example, if the only interaction between a mother and daughter is fighting, to take away fighting behavior is to threaten them with no relationship whatsoever. In this instance it is often better to employ paradoxical intent and ask them to intentionally fight every day. By requiring them to perform the problem behavior you take them one step closer to a solution by giving them control over the situation. Once in control, the situation becomes defused and participants can find other ways of relating. Ideally, the counselor does not present the solution to the family but rather creates the opportunity for the family to come up with its own solution.

Regardless of how simple the problem may appear or how obvious the solution may seem, remember that it is only the tip of an iceberg. The iceberg is made up of the complex values and interaction patterns within the family and those ties can feel as binding as any block of ice. It is probably not worth anyone's while to argue value systems with the family, nor is it helpful for the counselor to work harder or worry more than at least one other member of the family. There are many, many ways of achieving the small steps

in attitude and behavior change necessary for problem resolution. Techniques range from a simple restatement of the problem to the assessment of symptoms, the assignment of tasks, the negotiation of contracts and the teaching of skills. The possibilities are limited only by one's creativity and the necessity that the changes be within the context and control of the client.

EXERCISE

Purpose: To demonstrate the utility of a systems approach with a family.
Exercise: One person poses the problem situation involving an elderly client or an elderly family member. Small groups discuss:

1) What explanations to the problem could you hypothesize from the point of view of the individual client? What are the potential solutions?
2) What family members are potentially involved with the client?
3) What explanations could you hypothesize from the point of view of the family system? What are the potential solutions?
4) What are the differences between the individual's view and the system's view?

REFERENCES

Herr, J.J. and Weakland, J.H. Counseling Elders and their Families. NY: Springer Publishing Co., 1979.

Minuchin, S. Families and Family Therapy. Cambridge, Mass: Harvard University Press, 1974.

CHAPTER 5. THREE SPECIAL INTERVENTION TECHNIQUES

A. RESIDENT COUNCILS

Ellen Mack Bates

One of the vehicles for developing ways for residents of long-term care facilities to have some involvement and input into the activities of their daily lives is the resident council. Resident councils provide a network using the resources within the facility. A council can be the format through which residents have a forum for expressing their feelings about where they are, who they are, and what they can do to improve the quality of their lives. It can be the first step in moving toward some mutual satisfactions between the administration of the facility and the residents.

The council can include the members of a nursing home ward unit, boarding home or any in-house group; it provides the opportunity for the residents to have input in the planning and carrying out of areas such as house rules, educational and social activities. A council provides opportunities for residents to take part in and have some feelings of being in control of their lives. Councils provide an atmosphere that is conducive to accepting responsibility for their actions.

The following factors should be considered in the initial stages of a resident council.

Administrative Sanction: In order for a council to organize and function effectively, it is very important that the administration of the unit, department or home be actively involved in preliminary and ongoing planning and that it support whatever form the plan takes. Support may mean delegation of staff to work with the resident group, input and output to program planning, use of public relations networks and designating space that residents can use for formal and informal activities. Administration also defines those areas which residents cannot control, e.g., medical affairs.

The following steps may be taken to elicit administrative support:

1) Approach the administrator and discuss preliminary plans, setting up an appointment for further discussion.
2) At the meeting be prepared to outline tentative plans such as where and when to call residents together to discuss having a council, suggestions as to key residents who have leadership potential and who might be asked to attend the first planning session, what the initial topics for discussion will be and best time of day to have the meeting.
3) Have suggested program areas that residents may be interested in pursuing, such as having a movie brought in for the residents, going to a sports event as a group, starting a garden, working on already stated or first-time formalized house rules.
4) Keep program areas simple and easy to do, particularly when beginning.
5) Ask the administrator if the officers and staff delegated to work with the council can meet at regularly stated intervals to evaluate success and failures and to increase the communication flow between residents and staff.
6) Have some suggestions as to how you think the resident group can be organized in terms of formal and informal groups.

Planning with the Residents: In starting the resident council the staff delegated to work with the group and the residents themselves meet and discuss how the residents want to run their group. Do they want officers or would they prefer having a less formal decision-making group? The latter is more difficult to work with, particularly if the group is large.

The residents need to set regular meeting times, making sure that this time does not conflict with medical appointments. Residents are informed about the meetings through flyers, bulletin boards, announcements at meals and in-house newsletters. It is important to conduct the meeting during the specified time; long, drawn-out meetings are aversive. If the group decides to have dues, the amount should be minimal and support from the administration sought. Dues are preferable to donations when a program is planned.

In the first phases of forming a resident council, it is important that the programs planned be well within the capabilities of the residents. The greater the number of residents willing to accept diverse tasks, the greater the individual and group satisfaction. For example, the resident council may plan a cookout in the yard of the facility or at a nearby small neighborhood park. Committees might include: menu planning, food ordering and cooking, setting tables, serving the food, activities and cleanup.

It is important to plan those kinds of activities that the residents can and want to do. Some of those areas which may be appropriate are: rules pertaining to "lights out", possibilities of evening activities, bringing programs into the facility as well as going to events in the community. Educational areas should be explored as possibilities for program. It is possible to have community business and club groups present programs in areas such as grooming, preparing and serving inexpensive foods, fashion shows, etc.

In summary, the resident council, by whatever name it is called, offers a way for resident involvement in long-term care facilities. The resident council provides the residents with some degree of control over their lives by providing an opportunity for active participation in making suggestions and decisions. Residents learn or relearn how to function in a goal-oriented group, how to develop friendships and learn new skills, and how to feel like "somebody".

EXERCISE

Purpose: To understand the mechanics of forming a council and implementing council activities.

Exercise:

1) Each team chooses a member for an initial meeting.
2) Members meet and select several delegates to meet with administration and generate "reasonable" areas in which they might have some control over a "small part" of their daily lives.
3) Hold the meeting and negotiate.
4) Call a meeting of all "residents" and plan an activity.
5) Carry out the plan and evaluate.

B. SOCIAL SKILLS TRAINING

Helga Rhode and Lawrence Englander

Despite the fact that social skills training with an elderly population is a broad, poorly defined and minimally researched area, the teaching of social skills and assertion training is especially relevant. As age increases, there is a tendency toward reduced social reinforcement; this reduction frequently leads to the extinction of socially adaptive behavior. These factors may well contribute to the mood disturbances, low self-esteem, loss of feelings of control, alienation and loneliness often found in the elderly community. This is especially true since as age increases, an individual's life space often contracts due to loss of mobility and loss of significant others. Any attempt to teach social skills to the elderly is based on the value that life's pleasures should, whenever possible, be enhanced throughout the life span.

A behavioral approach is applicable to a broad population with diverse skill deficits, is a relatively short-term therapy which can produce rapid and beneficial behavioral change, emphasizes skill acquisition and avoids traditional labeling which may already be too prominent a part of the life of elderly persons.

Before an outline of the treatment approach is presented, it is important to define the targeted behaviors. Social skills are those behaviors that allow an individual to seek, maintain and enhance interactions within one's social environment. They are generally divided into two major categories: 1) verbal behavior, such as expressions of feelings, "I" statements and straightforward requests and refusals; 2) non-verbal behavior, such as proximity, body language and physical appearance. Assertive behaviors are those which enable a person to act in his/her own best interests, to stand up for oneself without undue anxiety and to express both positive and negative thoughts and feelings with comfort. These behaviors allow one to exercise rights without denying those of others.

The therapeutic intervention is based on a social interactional model in which the relationship is between student/teacher or group member/facilitator rather than patient/therapist. The overall goals of the training program ideally are: 1) improved social skills for coping, 2) personal control along with decreased helplessness and 3) awareness of the results of these changes.

As with any behavioral intervention program, the first step involves an assessment to identify the target behaviors. This assessment is based on self-report, diagnostic scales (e.g., Rathus Assertiveness Scale, Fear of Negative Evaluation Scale, Social Anxiety and Distress Scale) and an analysis of the environmental elements maintaining the problematic behaviors.

Because few individuals have a clear understanding of the elements of passive, aggressive and assertive actions, a thorough discussion of these terms is in order (Alberti and Emmons, 1978). Similarly, a discussion of the correlates of interpersonal attraction would help members recognize the relationships among personal grooming habits, similarity of interests, availability and the importance of maintaining or increasing social contacts.

The training is directed toward the improvement of both verbal and non-verbal communication skills. The specific techniques used could be all or a combination of several of the following: modeling assertive behavior, behavioral rehearsal by participants, coaching and corrective feedback. In addition to these techniques, cognitive restructuring (e.g., coping self-statements and self-reinforcement), cognitive rehearsal (e.g. covert modeling) and relaxation training will serve to enhance the effectiveness of the training program (Cautela and Mansfield, 1977). In cases of particular individual difficulties (e.g., extreme anxiety), progressive relaxation and systematic desensitization might be in order (Jacobson, 1938; Wolpe, 1973).

Treatment effectiveness can be significantly enhanced through the assignment of tasks which are specific, simple and which have a high probability of success (e.g., with an isolated individual assign the task of saying "hello" to three persons a day for one week). In order to further increase the effectiveness of the training program, follow-up sessions help promote maintenance of behavioral changes and generalization of these changes to the natural environment and an evaluation of the treatment program.

Finally, the following special considerations should be taken into account in formulating a social skills training program with the elderly client. The principles apply to work done with the client as well as with social networks.

1) Groups should be kept small (7 to 10 persons).
2) Sessions should be relatively short (approximately 1½ hours) and allow for a 20 to 30 minute break for socializing.
3) The facilitator(s) should perform the multiple roles of modeling appropriate social skills, acting as a socializing agent and as group participant.
4) Special attention should be given in the structuring and delivery of the training program to the importance of possible physical disabilities.
5) As with any other therapeutic endeavor, treating the older person with respect helps promote a receptive environment.

A cognitive behavioral approach is uniquely suited to social skills training for the elderly. This view is supported by the following factors: 1) the program's applicability to a broad range of populations and problems, 2) the relative ease and brevity of administration, 3) immediacy of treatment effect, 4) reduction of resistance due to emphasis on social coping and problem-solving rather than illness/treatment model, 5) applicability to cases of deficit and anxiety and 6) group orientation allows more social interaction and more individuals can be reached. Additionally, this treatment program lends itself to the utilization of professionals, paraprofessionals and can be taught to and implemented by members of the social network.

EXERCISE

Purpose: To practice problem behavior identification and to plan for intervention. Time required: 1 hour.
Exercise: Team members agree on a problem posed by an elderly client. One member (the facilitator) is not included. This person assesses the problem and intervenes to change the behavior.

REFERENCES

Alberti, R.E. and Emmons, M.L. Your Perfect Right (Third Edition). San Luis Obispo, CA: Impact, 1978.

Cautela, J.R. and Mansfield, L. A Behavioral Approach to Geriatrics. In Gentry, W.E., Geropsychology. Ballinger, 1977.

Jacobson, H.A. Progressive Relaxation. Chicago: University of Chicago Press, 1938.

Rathus, S.A. A 30 Item Schedule for Assessing Assertive Behavior. Behavior Therapy, 1973, 4, 398-406.

Watson, D. and Friend, R. Measurement of Social-Evaluative Anxiety. Journal of Consulting and Clinical Psychology, 1969, 83, 4, 448-457.

Wolpe, J. The Practice of Behavior Therapy (Second Edition). Pergamon Press, 1973.

C. THE REMINISCING PROCESS IN THE ELDERLY: LIFE REVIEW

Nancy Little

Clinical observation and current gerontological research indicate that the elderly are helped by mental health workers using a patient, sensitive, knowledgable ear while listening to an older person reminisce as he/she prepares for impending death. This can be a therapeutically meaningful experience. It is particularly beneficial when the life review process reawakens previously unresolved conflicts, which may need to be worked through and reintegrated more harmoniously in order to reduce anxiety or to alleviate depression (Butler, 1963; Butler and Lewis, 1974). Positive outcomes stemming from brief psychotherapy may manifest themselves sooner than in a younger population as a result of the older person's realization that the time left is growing short.

The mental process of reviewing one's life seems to be a universal and automatic phenomenon not only in the elderly but also in younger people who comprehend they may soon die from a terminal illness. This looking back process helps to explain why the elderly reminisce more frequently than other age groups and why at the end of the life cycle they are particularly susceptible to depression and anxiety. The life review outcome may enhance, maintain or sometimes regress personal psychosocial functioning.

Rethinking one's past reawakens all degrees of emotions. Reminiscing may precipitate mild nostalgia and regret or moderate anxiety, guilt and depression. Often the person expresses guilt over past wrongs or has some obsessional thoughts. The intensity of emotional reaction may be proportionate to the quantity and quality of the person's revived unresolved past conflicts and to past adaptive functioning. The sensitive clinician may explore further or change direction of the review depending on the client's affective response.

Having an objective listener present during this process, especially if unresolved conflicts are intense and disturbing, can influence change in the direction of increasingly adaptive functioning. Towards the adaptive end on a psychological functioning continuum, this reflective process may account for the qualities of wisdom and serenity manifested by some of the elderly. In the middle of the continuum, the process assists in maintaining a status

quo of psychological functioning. For example, this phenomenon is reflected when individuals fantasize about the past for the purpose of avoiding the present. This may not be growth-producing, but it keeps the person from deteriorating. Many behavioral and emotional states emerge during the life review, which on the maladaptive end may result in severe reactions. Instead of continued growth and development through enhanced self-awareness toward the end of the life cycle, increased rigidity occurs.

Isolation and confinement may perpetuate and intensify the elderly's emotional reaction while engaged in reminiscence. Severe emotional problems precipitated during the life review are more commonly found in individuals whose guilt is real, as a result of a conscious and deliberate effort to hurt others. Another susceptible group is comprised of those who do not enjoy living in the here and now because they continually strive for the future.

CASE ILLUSTRATION

The life review process was utilized with an 87 year old woman who had been active and enthusiastic prior to her placement in a nursing home because of her deteriorating physical condition. Over a two-year period, the woman became increasingly depressed, withdrawn and frightened about dying.

During the course of a few months, while recounting her life story, she was able to reorganize, resolve and reintegrate some of her current thoughts and feelings of helplessness and depression. She appreciated having an objective listener take an interest in her past achievements. Her depression stemmed mostly from her confinement in the nursing home. As her life story unfolded, her depression lifted. Through her recounts she seemed to realize that she had lived her life the way she had wanted. It is clear that prior to her placement, the woman led a well-adjusted life. For a less well-adjusted individual, it would have been more important to emphasize the integration of past life experiences as the person <u>had</u> lived them, not as they <u>might</u> have.

As this woman talked about how she loved her life, she began to discuss how she would face dying in a serene and dignified manner. She became less afraid and regretful of her impending death as she discussed her past achievements. She felt more satisfied with herself and her age. Reorganizing her thoughts and feelings brought back a widsom and inner peace that had been submerged for two years. An important aspect of the positive outcome was her life-long characteristics of resiliency, flexibility and adaptiveness.

A life review which is undertaken by an elderly individual near the end of the life cycle cannot be dismissed as a senile attempt to relive the past. One purpose of such reflection is to reintegrate and resolve recurring emotional difficulties. Mental health professionals and social network members may prove helpful to the elderly person by tapping into the already existing process through monitoring and steering the outcome towards a positive, adaptive result.

Several techniques are useful in rendering the life review more conscious, purposeful and therapeutic. Writing or tape recording autobiographies is a relatively nonthreatening method that allows the individual to delve into memories. This is not only helpful for professionals but can also be important to family members as a means of opening up communication channels. Having elderly persons listen to their taped autobiography may help them identify conflictual areas that need reintegration. These tapes may be the only legacy the older person leaves to family members.

If possible, the individual may be encouraged to travel to his/her birthplace or hometown. This may aid in uncovering and elucidating past experiences. Such pilgrimages give a sense of continuity to the past and present and help individuals prepare for death in a more stabilized fashion. Attending reunions may help the person feel less isolated. Encouraging an interest in personal genealogy not only enhances the perpetuation of a generational life cycle but also opens up issues linked with immortality and death.

Scrapbooks, photographs and letters are other means through which the elderly (and others such as mental health workers and social network members) may facilitate communication. Creativity and a feeling of accomplishment are stimulated by asking individuals to work on written, verbal or artistic summations of their lives. In compiling family albums and genealogies, an older person is given the opportunity to teach younger generations about their roots, thereby broadening the identity of subsequent generations.

The life review process is a useful technique both in aiding the elderly person to achieve what Erikson (1963) has called egocentricity and in anchoring the social network to that person in time and space, thought and feeling.

EXERCISE

Purpose: To experience personal reminiscing and facilitate reminiscing by another individual. Time required: 2 hours (2 separate sessions).
Exercise: Team members break off in pairs.
First session: Each takes a turn conducting a "Life Review" with the other. In many ways this is similar to the social history, but go with the person and follow the "byways", not only the "highways." Homework: What photos, momentos, scrapbooks, etc. might evoke more memories?
Second session: Continue with the reminiscing using the materials which have been brought in. Integrate the review with the person.

REFERENCES

Butler, R.N. The Life Review: An Interpretation of Reminiscence in the Aged. Psychiatry, 1963, 26, 65-76.

Butler, R.N., Lewis, M.I. Life Review Therapy: Putting Memories to Work in Individual and Group Psychotherapy. Geriatrics, 1974, 165-173.

Erikson, E. Childhood and Society. Norton, 1963.

Havighurt, R.J. and Glasser, R. An Exploratory Study of Reminiscence. Journal of Gerontology, 1972, 27, 245-253.

Liton, J., Olstein, S.C. The Specific Aspects of Reminiscence. Social Casework, 1969, 50, 263-268.

McMahon, A.W. and Rhudick, P.J. Reminiscing: Adaptational Significance in the Aged. Arch. Gen. Psychiatry, 1964, 10, 294.

CHAPTER 6. TWO SPECIAL ISSUES AS RELATED TO THE ELDERLY

A. MEDICATIONS: USE AND ABUSE

Evelyn S. Paley

WARNING: Medications may be hazardous to the health of an older person! A sudden change in behavior warrants immediate inquiry into drug use. Symptoms such as confusion, loss of memory and unsociability are causes for alarm in the person, family and social network. These symptoms have all the dreaded implications of "senility." A crisis call to the mental health center or a trip to the emergency room may result in precipitous and unwarranted admission to a nursing home or a psychiatric ward, where one of five persons admitted is experiencing a toxic drug reaction.

Persons over 65 consume 25 percent of all prescribed drugs and this does not include home remedies and over-the-counter drugs. This might be expected since 80-86 percent of older persons suffer from at least one chronic disease such as cardiovascular and heart disorders, arthritis, diabetes and emphysema. Despite the primary physiologic nature of these conditions, the most prescribed drugs are psychoactive such as valium, librium, sedatives such as phenobarbitol, and analgesics (e.g. Darvon). Eighty percent of acute drug reactions among older persons involve misuse of a sedative or tranquilizer. In addition to caffeine, alcohol and over-the-counter drugs (e.g. Sominex, Nytol), one-third of the over-60 population ingest five or more drugs simultaneously. It is no wonder that a psychiatrist coined the term "Spaced-out-Grandma" syndrome to denote the overchemicalization of older persons using both prescription and non-prescription drugs (Green, 1978).

The problem results from many interacting factors: the physician's training and experience with geriatrics, the older client, the drug industry and cultural norms. Only the physician may prescribe drugs. To the current generation of elderly persons (and possible to all groups), the physician's role as healer is not only legitimate but also powerful. Yet the physician's training in understanding and treating older patients may have been minimal. Most physicians are not aware of the special biological, psychological and social needs of the elderly patient.

Since 70 percent of all drugs available today were unknown fifteen years ago, the complex interactive effects of the drugs are not generally known. Much of the information about drugs is imparted by the pharmaceutical detail person whose job it is to acquaint the physician with the newest available medications and to dispense samples for the physician's use. The directions on the trial package promise instant knowledge of the effects and side-effects of the drug (Green, 1978).

Older persons have an increased incidence of physical illness, consume proportionally more drugs and are, therefore, more vulnerable to drug misuse. Since medications may, even in smaller doses, be more active in older persons due to anatomical and physiological changes, they are more prone to have and to be affected by adverse drug reactions.

The incidence of mental problems increases with age (Butler & Lewis, 1973). The utilization of mental health services, however, is low. A prescription

for psychoactive drugs often takes the place of appropriate referral for reversible mental disorders and certainly removes the sociocultural stigma associated with treatment for psychological disorders such as anxiety and depression.

The cultural myths about older persons have contributed to the abuse of medications which are prescribed for the "dependent, senile, isolated, lonely and depressed" older person. Psychoactive drugs are prescribed rather than medications specific to the primary medical problems. The person also is affected by the self-attribution of those characteristics. Along with the fear of becoming ill, the hope that "it will go away" and financial problems, older persons purchase the over-the-counter drugs touted as cure-alls by the media. They may also tend to use home remedies, to use what was earlier prescribed, what helped a friend, to overdose - "if one pill is good, two may be better", and to take a drug longer than needed.

Many medications have adverse effects due to a combination of alcohol with other drugs including non-narcotic analgesics such as aspirin. Central nervous system functioning may be depressed. Sedatives, tranquilizers and antidepressants taken in combination may have inhibitory effects on the metabolism of each other.

To repeat the warning: Any sudden behavior change that appears as a confusional state may be due to drug toxicity. It is important for the mental health center worker to alert the elderly client, the family and the social network about this possibility and to engage medical assistance immediately. What appears to be irreversible "senility" may be completely reversible. The array of medications used may be causing the confusional state.

EXERCISE

Purpose: To understand more about drug use.

Exercise: Each team member assesses his/her own medicine cabinet, listing the prescription drugs, over-the-counter drugs and home remedies, dates prescribed or purchased. Do you know the effects, side-effects and interactive effects? Consult your staff (or personal) physician if you do not know.

REFERENCES

Green, B. The Politics of Psychoactive Drug Use in Old Age. Gerontologist, 1978, 18, 6.

Gutmann, D. A Study of Legal Drug Use by Older Americans. Washington, D.C.: AOA, NIDA, May, 1977.

Hollister, L.E. Clinical Use of Psychotherapeutic Drugs. Springfield, IL: Thomas, 1974.

Kayne, R.C. (Ed.). Drugs and the Elderly. Los Angeles: Andrus Gerontology Center, USC, 1978.

Petersen, D.M., Whittington, F.J. and Payne, B.P. Drugs and the Elderly: Social and Pharmacological Issues. Springfield, IL: Thomas, 1979.

Vancura, E.J. The Effects of Medication: Utilization Review. Creative Approaches to Aging Mental Health Seminars, Ebenezer Society, 1977.

B. EXERCISE AND AGING

Timothy Dea

Physical exercise level in late adulthood decreases at an alarming rate. The 1972 National Adult Fitness Survey found that only 39 percent of Americans over 60 get any systematic exercise. For those who exercised, the favorite activity was walking, in which 46 percent of the men and 33 percent of the women were engaged. More vigorous activities occurred with much less frequency; of those who exercised, 6 percent engaged in calisthentics, 4 percent in swimming, 3 percent in bicycling, 1 percent in jogging and 1 percent (men only) in weight lifting (Physical Fitness Research Digest, 1977).

Attitudes held by older adults foster this low level of exercise. Conrad (1976) explicated four such attitudes:

1) The elderly believe their need for exercise diminishes and eventually disappears as they grow older.
2) They vastly exaggerate the risks involved in vigorous exercise after middle age.
3) They overrate the benefits of light, sporadic exercise.
4) They underrate their own abilities and capacities.

In addition, the aches and pains of old age diminish the desire for and reenforcement of exercising. Also, western cultures are taught that the body and the mind are a duality. The link between physical vigor and mental health is not understood.

Physical, Psychological and Social Implications of Exercise: Chronological age in itself does not produce physical problems. The rate of aging and the manifestations of the aging process are directly affected by the use, disuse and abuse of our bodies.

> "What we have done with our selves, how we have done it, how frequestly we have done it, and how it felt to be doing it are all reflected in the way we have developed our muscles, bones, and neuromuscular coordination." (Dychtwald, 1977, p. 20)

Various physical traumas experienced during the life cycle affect the ability to exercise. If a hip has been broken and movement compensating for this disability is adopted, eventually the muscles lose their ability to relax and flex appropriately and the tension becomes chronic. We are susceptible to disease and death because certain vital parts wear out earlier than others. Parts of the body which are regularly exercised remain strong and fluid.

Physical exercise affects a host of physiological processes which are involved in the aging process. Exercise improves circulation and respiration by increasing the fitness of the cardiovascular and blood transport system, thereby suffusing the body tissues with a rich blood supply. Beneficial changes are seen in heart rate, blood pressure, cardiac output, aerobic and anaerobic power. Oxygen consumption increases which in turn affects heart and lung capacity and cerebral functioning. Exercise stimulates tissue regeneration and restores tissue elasticity. Not only does this increase the smooth, painless functioning of the joints, it also increases arterial wall

elasticity which retards arteriosclerosis. Physical activity makes bones more resilient, strengthens muscles, ligaments and tendons, and aids in fat reduction. The biological changes triggered by exercise have far-reaching consequences for retarding the aging process and creating healthy later years with a shorter period of disability and disease prior to death (de Vries, 1974; Physical Fitness Digest, 1977).

Physical exercise also enhances psychological well being. Exercise increases energy, reduces fatigue, stimulates better sleep and diminishes stress. Anxiety and depression decrease markedly. Regular exercise also improves self concept, emotional stability, assertiveness, extroversion and self-sufficiency (deVries, 1974; Physical Fitness Digest, 1977).

Recreational activities are an important part of a comprehensive health program and are also ideal in stimulating social participation. Shared activities such as dancing, walking and exercise classes combine the mutually enjoyable interactions necessary in the formation of social networks. Groups not only improve their physical condition but they also form a unity of purpose which increases intimacy and support.

Exercise Guidelines:

1) Medical monitoring is very important. Physical exams and information from the client's physician about appropriate exercises need to be obtained.
2) Individuals require programs tailored to their past and current history of exercising and the consequences of disease and injury including sensory deficits.
3) Awareness and acceptance of physical strengths and weaknesses helps avoid overstressing any body parts. Encourage exploration and patient stretching of the limits.
4) Excessive exercise is physically harmful, creates negative attitudes and decreases the likelihood of continuing on an exercise program.
5) Isotonic (moving) exercises rather than isometric (static) exercises should be encouraged. Isometric exercises may elevate blood pressure and overtax the body.
6) Following injury or disease progressive exercises are essential. Do not prolong inactivity.
7) Improvement is slower in late adulthood. The performance capacities of youth will never be regained. Exercise programs should start at the individual's level, include short term goals and rewards for reaching these goals. The President's Council on Physical Fitness and Sports and the Administration on Aging have tailored a physical exercise regimen which includes a graded series of cardiovascular and muscle stretching exercises and allows entry at one's own level of fitness.
8) Exercise should be done on a regular basis, employing a variety of activities. Stress on the system can be equalized by frequently shifting the work from one part of the body to another. The body is only as strong as its weakest link.

> "The human body--like the tires of a car, or the rug on a floor, wears longest when it wears evenly . . . the more we vary our actions, the less one part suffers from attrition." (Selye, 1976, p. 433)

9) Include both active and passive exercises. Active, aerobic exercises such as walking, running, biking and swimming increase muscular tone, flexibility, strength and endurance. Passive exercises such as yoga and deep breathing decrease muscle tension and promote relaxation. Ta'i Chi Chuan and yoga are particularly suited to improve joint flexibility as well as mental clarity. They combine mental concentration, coordination of breathing, stretching and graceful body movement.
10) Originality is the key to successful program planning. Gardening and mowing the lawn, emptying the trash and other household chores are readily available conditioning activities. Sexual activity and massage are intimate interactions with excellent rejuvenating properties.
11) Stimulate the social network to plan group activities. A grandfather and grandchild may take regular walks to the park. A family could plan picnics including hikes to and from the area. A resident council could organize a dance or form a bowling team. Explore activities that the network can enjoy as a group.

A wide scope of exercise promotes physical and psychological health and provides an excellent channel for social interaction. Education regarding the beneficial effects of physical activity and trainability during the entire life cycle need to be imparted to the elderly, the helping professions and the involved social network. Exercise does not stop aging, but when properly applied, it increases individual and group vigor and adds life to the years of the elderly.

EXERCISE

Purpose: To increase awareness of physical limitations and to experience limitations on physical activity. Materials needed: Eyeglasses and vasoline or dark glasses; cardboard and tape or ace bandages; ear plugs or cotton balls.

Exercise: Simulate visual impairment by wearing glasses smeared with vasoline or by wearing dark glasses. Simulate mobility impairment by taping the cardboard or ace bandages over elbows, knees or finger joints. Simulate auditory impairment by plugging the ears with cotton balls or ear plugs. Walk around the room or up a flight of stairs with bandages on; view a film or watch television with glasses on; listen to a conversation with another individual or in a group while wearing ear plugs. Encourage group discussion pertaining to thoughts and feelings about your impairment. Discuss the repercussions these disabilities have for an exercise program.

REFERENCES

deVries, H.A. Vigor Regained. NY: Prentice Hall, 1974.
Hrachovec, J. Keeping Young and Living Longer. LA: Sherbourne Press, 1973.
Pollock, M.L. An Aerobic Fitness Program for Adults. Journal of Physical Education and Recreation, 1976, 47, 9, p. 15.
Presidents Council on Fitness and Sports. Physical Fitness Research Digest, April 1977, Series 7, No. 2
Presidents Council on Physical Fitness and Sports and the Administration on Aging. The Fitness Challenge in the Later Years: An Exercise Program for Older Americans. DHEW Pub. # (OHD) 75-20802, May 1968.
Salye, H. The Stress of Life. NY: McGraw Hill, 1976.